

## Economic Factors Influencing Healthcare Access and Health Outcomes Among Residents of Salaama Parish, Makindye Division, Kampala.

### A cross-sectional study.

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#### ABSTRACT

##### Background:

Income levels and employment status are significant determinants of healthcare access. Low-income households are more likely to delay or forgo healthcare due to financial constraints. The study aims to investigate the economic factors impacting health outcomes in Salaama Parish.

##### Methodology:

The study employed a cross-sectional design with both quantitative and qualitative components. The sample size for this study was calculated using Slovin's formula, resulting in a sample size of 100 participants. Data verification was also conducted to re-check data against sources, validate data entry, and ensure data consistency. Double data entry and automated checks for errors and inconsistencies were used to ensure data entry quality.

##### Results:

Financial constraints significantly limited healthcare access among respondents. Fifty-two per cent reported that financial difficulties always or often affected their ability to seek care, while 74% had delayed or avoided healthcare because of costs. Additionally, 76% could not afford medications and routine checkups. Health insurance coverage was low, with only 10% insured, mainly through private insurance. Among uninsured respondents, lack of awareness (27%) and limited availability (14%) were major barriers. Although 48% rated their healthcare access as good or very good, 46% reported insufficient income despite employment, while 35% identified unemployment as a barrier. Furthermore, 78% believed their living conditions affected their health. 57% of respondents were female, while 43% were male.

##### Conclusion:

Economic factors significantly hinder healthcare access in Salaama Parish, particularly through financial constraints, inadequate income, unemployment, and limited insurance coverage. Strengthening affordable healthcare programs and financial protection for vulnerable groups is essential to improve healthcare access and health outcomes.

##### Recommendations:

Economic barriers to healthcare access can be significantly reduced by implementing affordable, government-subsidised healthcare programs targeting vulnerable groups like children, pregnant women, and the elderly.

**Keywords:** *Economic factors; Healthcare access; Financial constraints; Health insurance; Employment status; Salaama Parish.*

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#### Background

In urban Uganda, including Kampala, economic constraints such as high out-of-pocket expenses, lack of health insurance, and unemployment limit access to necessary healthcare services (Nabbanja & Waiswa, 2019). Studies reveal that in Salaama Parish, residents from low-income backgrounds struggle to afford routine check-ups, medications, and preventive services, leading to increased vulnerability to preventable diseases and complications from untreated conditions (Nakayima et al.,

2020). Income levels and employment status are significant determinants of healthcare access. Low-income households are more likely to delay or forgo healthcare due to financial constraints (World Health Organisation [WHO], 2021). In rural Ugandan settings, studies have shown that individuals earning less than \$2 per day often struggle to afford transportation to health facilities, let alone treatment costs (Mugisha et al., 2016). In low-resource settings, inadequate housing quality is often associated with environmental hazards, including

exposure to pests and unsafe drinking water, which exacerbate health disparities (Clair et al., 2019). Improving housing conditions has been shown to significantly reduce the burden of preventable illnesses, particularly in vulnerable populations. Reliance on biomass fuels for cooking in poorly ventilated homes continues to be a leading cause of indoor air pollution, responsible for respiratory illnesses in women and children (Bonjour et al., 2017). Policies promoting access to clean energy and sanitation have been shown to significantly improve health outcomes in such contexts. The geographical location of housing plays a critical role in healthcare access. Rural households often reside far from healthcare facilities, facing challenges such as poor road infrastructure, limited transportation, and high travel costs. Studies have found that the distance to healthcare services disproportionately impacts women and elderly residents in rural areas, leading to delays in seeking treatment and higher mortality rates (Kundu et al., 2022). Proximity to healthcare services is also influenced by housing policies, with urban informal settlements often located far from hospitals or clinics. Addressing these geographic barriers is essential for improving equitable healthcare access. The study aims to investigate the economic factors impacting health outcomes in Salaama Parish.

## Methodology

### Research Design

The study employed a cross-sectional design using quantitative methods to examine socioeconomic disparities in access to healthcare and health outcomes in Salaama Parish. The mixed methods approach allowed for triangulation of findings, providing a comprehensive understanding of the research topic.

### Area of the Study

The study focused specifically on Salaama Parish, a peri-urban area within Makindye Division in Kampala, Uganda. Salaama Parish was selected due to its distinct mix of urban and semi-rural characteristics, high population density, and socioeconomic diversity, which create unique challenges in healthcare access and outcomes. The area includes a combination of low-income residential neighbourhoods and informal settlements, where residents face issues such as limited healthcare facilities, high poverty rates, and inadequate infrastructure.

The population of Salaama Parish is diverse, comprising various ethnic and socioeconomic groups. The area is home to approximately 120,000 residents, growing at a rate of around 4% per year, with a high population density similar to other densely populated parts of Kampala. Many residents work in informal sectors or small-scale businesses, with limited access to stable income and health insurance. Vulnerable groups, including women, children, the elderly, and individuals with chronic

illnesses such as diabetes and hypertension, make up a significant portion of the population and are particularly impacted by healthcare access disparities.

Salaama's unique demographic and socioeconomic profile makes it a suitable location for examining socioeconomic disparities in healthcare access and outcomes. The study aimed to address research gaps by focusing on how social and economic factors influence healthcare utilisation and health outcomes, with an emphasis on vulnerable populations in the area. Insights from this study will help inform targeted policies and interventions to improve healthcare access and reduce health inequities within similar urban and peri-urban contexts.

### Population of the Study

The study population consisted of approximately 133 participants selected from Salaama Parish in the Makindye Division of Kampala. This population size was determined based on feasibility and the scope of a bachelor's-level study, balancing the need for diverse representation with available time and resources. A systematic random sampling method was employed across the different zones of Salaama Parish to ensure representation from a variety of socioeconomic backgrounds. The figure of 133 participants does not represent the total population of Salaama Parish, but rather the subset selected for primary data collection in this study.

Participants included household heads, local healthcare providers for example, nurses or community health workers, community leaders, and patients & caregivers. The study focused on residents aged 18-65 years, with attention to capturing diverse backgrounds in terms of income levels, education, and healthcare experiences.

This specific, smaller sample size allowed for a focused examination of socioeconomic factors influencing healthcare access and outcomes in Salaama Parish, while remaining feasible for a bachelor's level research project.

### Sample Size and Sampling Techniques

The sample size for this study was calculated using Slovin's formula, resulting in a sample size of 100 participants, which was derived from a population of 133 individuals. This sample size was deemed sufficient to ensure representativeness and reliability of the findings.

Slovin's formula is:

$$n = N / (1 + (N(e^2)))$$

where:

n = sample size

N = population size

e = margin of error (as a decimal)

Given:

N = 133 (population size)

e = 0.05 (5% margin of error)

Plugging in the values:

$$n = 133 / (1 + (133 * 0.05^2))$$

$n = 133 / (1 + (133 * 0.0025))$   
 $n = 133 / (1 + 0.3325)$   
 $n = 133 / 1.3325$   
 $n = 99.81238274$   
 $n \approx 100$  respondents.  
Household heads:

$n = 48 / 1 + 133(0.5)^2$   
 $n = 48 / 1 + 133(0.0025)$   
 $n = 48 / 1 + 0.3325$   
 $n = 48 / 1.3325$   
 $n = 36.02251407$   
 $n \approx 36$  respondents.

Healthcare providers:

$n = 28 / 1 + 133(0.5)^2$   
 $n = 28 / 1 + 133(0.0025)$   
 $n = 28 / 1 + 0.3325$   
 $n = 28 / 1.3325$   
 $n = 21.01313321$   
 $n \approx 21$  respondents.

Community leaders/local council officials:

$n = 16 / 1 + 133(0.5)^2$   
 $n = 16 / 1 + 133(0.0025)$   
 $n = 16 / 1 + 0.3325$   
 $n = 16 / 1.3325$   
 $n = 12.00750469$   
 $n \approx 12$  respondents.

Patients/caregivers:

$n = 41 / 1 + 133(0.5)^2$   
 $n = 41 / 1 + 133(0.0025)$   
 $n = 41 / 1 + 0.3325$

$n = 41 / 1.3325$   
 $n = 30.76923077$   
 $n \approx 31$  respondents.

### Sampling Techniques:

#### Stratified Sampling:

##### Occupation stratification

Formal sector employees, Informal sector employees, Unemployed, and Self-employed

##### Education level stratification

Primary education or less, Secondary education, and post-secondary education

##### Healthcare access experience stratification

Those with access to healthcare

Those without access to healthcare

#### Purposive Sampling:

##### Healthcare providers

Doctors, Nurses, and Administrators

##### Community leaders

Local council officials

Village health teams (VHTs)

##### Patients and caregivers

Those with chronic conditions

Those with acute conditions

#### Random sampling

Household heads.

### Sample Size Distribution:

**Table 1: Sample Size Distribution**

| Category                                     | Population | Sample size | Percentage (of total sample) | Sampling tech |
|----------------------------------------------|------------|-------------|------------------------------|---------------|
| 1. Household heads                           | 48         | 36          | 36%                          | Random        |
| 2. Healthcare providers                      | 28         | 21          | 21%                          | Purposive     |
| 3. Community leaders/local council officials | 16         | 12          | 12%                          | Purposive     |
| 4. Patients/caregivers                       | 41         | 31          | 31%                          | Purposive     |
| <b>TOTAL</b>                                 | <b>133</b> | <b>100</b>  | <b>100%</b>                  |               |

### Inclusion/Exclusion Criteria:

#### Inclusion:

1. Salaama residents aged 18-65 years

#### Exclusion:

1. Individuals with severe cognitive or physical impairments

### Data Collection Methods and Instruments

#### Household Surveys

Household surveys were conducted using structured questionnaires administered to household heads or representatives. The questionnaire covered social and economic characteristics, healthcare access, utilization, and health outcomes. The Study conducted face-to-face interviews, ensuring confidentiality and anonymity. The

survey collected data on demographics, income, education, occupation, housing quality, healthcare usage, health insurance, distance to healthcare facilities, and self-reported health status.

### Survey Questionnaire

The questionnaire consisted of four sections. Section A: Identity Characteristics of the Respondents collected demographic information such as age, gender, education level, employment status, and marital status to provide background on respondents' socioeconomic status. Section B: Social Factors Affecting Healthcare Access assessed health literacy, cultural beliefs, traditional medicine preferences, and family or community support in accessing healthcare. Section C: Economic Factors Affecting Healthcare Access and Health Outcomes examined financial constraints, affordability of medical services, health insurance coverage, employment status, living conditions, and access to clean water and sanitation. Section D: Barriers and Potential Interventions identified major barriers to healthcare access, such as facility shortages, costs, and transportation challenges, while gathering respondents' input on potential solutions and community health programs to improve healthcare accessibility.

### Data Quality Control

To ensure data quality, the study pre-tested and validated survey instruments, trained enumerators and moderators, conducted regular supervision and monitoring, ensured confidentiality and anonymity, and used secure data storage and management systems. These measures guaranteed the accuracy, reliability, and validity of the collected data.

### Data Collection Tools

Data collection tools included survey questionnaires and IDI guides. These tools were designed to capture relevant data, ensure consistency, and facilitate data analysis.

### Quality Control Methods

#### Pre-Data Collection Quality Control

To ensure data quality, several measures were taken before data collection began. Firstly, the survey questionnaire and IDI guides underwent pilot-testing to validate their effectiveness, clarity, and cultural sensitivity. Enumerators and moderators underwent comprehensive training sessions, role-playing exercises, and field practice to ensure they understood the data collection tools and protocols. Additionally, mock interviews and focus groups were conducted to pre-test the instruments and refine procedures.

#### During Data Collection Quality Control

During data collection, regular supervision was conducted by the field supervisor to monitor the data collection

progress, provide feedback to enumerators, and ensure data accuracy. Data validation was also performed to verify data accuracy during collection, checking for inconsistencies and errors, and correcting errors promptly.

### Post-Data Collection Quality Control

After data collection, data cleaning was performed to check for errors, inconsistencies, and missing values, verifying data against sources and correcting errors. Data verification was also conducted to re-check data against sources, validate data entry, and ensure data consistency. Double data entry and automated checks for errors and inconsistencies were used to ensure data entry quality.

### Data Analysis Quality Control

During data analysis, data exploration was conducted to examine data distribution, outliers, and missing values. Statistical analysis was applied to test hypotheses and research questions, interpreting results and ensuring validity. Quality control checks were also performed, including consistency checks to verify responses across questions, reliability checks to assess internal consistency, and validity checks to evaluate construct validity.

### Data Storage and Security

To protect participant confidentiality and ensure data security, data were stored in password-protected databases, encrypted, and regularly backed up. Access was limited to authorised personnel, using secure login protocols and monitoring data access.

### Quality Control Team

A dedicated quality control team was responsible for ensuring data quality, comprising a field supervisor, data manager, and principal investigator. Each team member oversaw specific aspects of data collection and analysis.

### Data Analysis Techniques

Data analysis employed a mixed-methods approach, integrating both quantitative and qualitative methods. Quantitative data were analysed using descriptive statistics for socioeconomic characteristics, healthcare access, and health outcomes. Statistical software, including SPSS, facilitated analysis.

Data visualisation employed tables, figures, and charts to present findings. Data analysis procedures included data cleaning and preparation, data exploration, descriptive statistics, qualitative data coding, theme identification, and results interpretation.

### Ethical Considerations

This study adhered to ethical principles to ensure participants' rights and dignity were respected. Informed consent was obtained from all participants, explaining the study's purpose, risks, benefits, and confidentiality

measures, and participants were informed of their right to withdraw at any time without penalty.

Confidentiality and anonymity were maintained through coded identifiers, secure data storage, and password protection. Special consideration was given to vulnerable populations, such as children, pregnant women, and individuals with chronic illnesses, with additional safeguards in place, including medical screening for pregnant women and medical clearance for individuals with chronic conditions.

Conflicts of interest were disclosed, and measures were taken to prevent bias. Data sharing and dissemination were restricted to authorised personnel, with findings published through peer-reviewed outlets. The study upheld the principles of autonomy, beneficence, non-maleficence, and justice, which ensured voluntary participation and advanced knowledge on healthcare access and outcomes while safeguarding participants' rights throughout the process.

## FINDINGS

### Demographic characteristics of respondents

#### Age of Respondents

**Table 2: Age Distribution of Respondents**

| Years       | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------------|-----------|---------|---------------|--------------------|
| Valid 18-29 | 45        | 45.0    | 45.0          | 45.0               |
| 30-44       | 21        | 21.0    | 21.0          | 66.0               |
| 45-54       | 16        | 16.0    | 16.0          | 82.0               |
| 55-65       | 18        | 18.0    | 18.0          | 100.0              |
| Total       | 100       | 100.0   | 100.0         |                    |

The information in Table 2 shows that 45% of respondents were aged 18-29, making this the largest age group. In contrast, only 16% of respondents were aged 45-54, the smallest age group. This suggests that most respondents were young people who comprehended the study variables well.

#### Gender of Respondents.

**Table 2: Gender of respondents.**

| Gender       | Frequency | Percent | Valid Percent | Cumulative Percent |
|--------------|-----------|---------|---------------|--------------------|
| Valid Female | 57        | 57.0    | 57.0          | 57.0               |
| Male         | 43        | 43.0    | 43.0          | 100.0              |
| Total        | 100       | 100.0   | 100.0         |                    |

57% of respondents were female, while 43% were male. The higher female participation can be attributed to their common roles as household representatives, caregivers for patients, and healthcare providers, making them more accessible for the study. This gender distribution highlights the central role women play in healthcare access and decision-making at the household level, which may influence overall health outcomes in the community.

#### Level of Education

**Table 3: Level of Education of Respondents**

| Level of Education  | Frequency | Percent | Valid Percent | Cumulative Percent |
|---------------------|-----------|---------|---------------|--------------------|
| Valid Primary       | 21        | 21.0    | 21.0          | 21.0               |
| Secondary           | 26        | 26.0    | 26.0          | 47.0               |
| University          | 42        | 42.0    | 42.0          | 89.0               |
| Didn't go to school | 11        | 11.0    | 11.0          | 100.0              |
| Total               | 100       | 100.0   | 100.0         |                    |

42% have attained university education, followed by 26% with secondary education and 21% with primary education. A smaller portion, 11%, reported having never attended school. This distribution is also reflected in the accompanying bar graph, Figure 2, which illustrates the frequency of respondents across different education levels. The cumulative percentage indicates that by the

university level, 89% of respondents have received some form of formal education, while the remaining 11% have not. These findings suggest that a significant proportion of the population has achieved higher education, which may influence socioeconomic factors such as employment opportunities, healthcare access, and overall well-being.

## Employment Status

**Table 4: Employment Status of Respondents**

| Employment Status | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------------------|-----------|---------|---------------|--------------------|
| Valid             |           |         |               |                    |
| Employed          | 61        | 61.0    | 61.0          | 61.0               |
| Housewife         | 15        | 15.0    | 15.0          | 76.0               |
| Unemployed        | 24        | 24.0    | 24.0          | 100.0              |
| Total             | 100       | 100.0   | 100.0         |                    |

Most respondents (61%) are employed, while 24% are unemployed and 15% are housewives. This trend is also reflected in the bar graph, Figure 3, where employment is the most common status. The cumulative data reveals that 76% of respondents are engaged in either work or household responsibilities, while a quarter of the

population remains unemployed. These findings highlight the economic activity in the area while also pointing to potential challenges in job availability and gender roles in employment, which have an effect on healthcare access and health outcomes in the community.

## Marital Status

**Table 5: Table Showing Marital statuses of respondents**

| Marital status      | Frequency | Percent | Valid Percent | Cumulative Percent |
|---------------------|-----------|---------|---------------|--------------------|
| Valid               |           |         |               |                    |
| Single              | 36        | 36.0    | 36.0          | 36.0               |
| Married             | 50        | 50.0    | 50.0          | 86.0               |
| Divorced/ Separated | 10        | 10.0    | 10.0          | 96.0               |
| Widowed             | 4         | 4.0     | 4.0           | 100.0              |
| Total               | 100       | 100.0   | 100.0         |                    |

Half of the respondents (50%) are married, while 36% are single. They also show that 10% are divorced or separated, and 4% are widowed. The data indicates that marriage is the most common status, followed by single individuals, with a smaller proportion having experienced separation, divorce, or widowhood. These trends have implications for household structures, economic stability, and social support systems within the community.

## Economic Factors Affecting Healthcare Access and Health Outcomes.

### How frequently do financial constraints affect your ability to seek medical care?

**Table 7: Table Showing How Frequently Financial Constraints Affect the Respondents' Ability to Seek Medical Care.**

| How frequently do financial constraints affect your ability | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------------------------------------------------------------|-----------|---------|---------------|--------------------|
| Valid                                                       |           |         |               |                    |
| Always                                                      | 37        | 37.0    | 37.0          | 37.0               |
| Often                                                       | 15        | 15.0    | 15.0          | 52.0               |
| Sometimes                                                   | 23        | 23.0    | 23.0          | 75.0               |
| Rarely                                                      | 19        | 19.0    | 19.0          | 94.0               |
| Never                                                       | 6         | 6.0     | 6.0           | 100.0              |
| Total                                                       | 100       | 100.0   | 100.0         |                    |

The results indicate that a significant portion of respondents frequently experience financial barriers when accessing healthcare.

37% of respondents reported that financial constraints "always" affect their ability to seek medical care, making this the most commonly reported challenge. This suggests that a considerable proportion of the population faces persistent economic hardships that hinder their access to essential health services.

15% indicated that financial constraints "often" impact their healthcare access, bringing the cumulative percentage to 52%, meaning that more than half of the respondents frequently struggle with affordability issues when seeking medical care.

23% stated that they are "sometimes" affected by financial constraints, showing that a sizable portion of the population occasionally experiences difficulties in

affording healthcare, though not as consistently as the first two groups.

19% mentioned that financial barriers “rarely” impact their healthcare access, suggesting that some individuals

face only minimal economic obstacles when seeking medical treatment.

6% reported that financial constraints “never” affect their access to medical care, indicating that a small minority does not experience financial barriers to healthcare access.

### Are You Able to Afford Medications and Routine Checkups?

**Table 8: Table Showing Respondents' Ability to Afford Medications and Routine Checkups.**

| Ability to afford medications and Routine Checkups |       | Frequency | Percent | Valid Percent | Cumulative Percent |
|----------------------------------------------------|-------|-----------|---------|---------------|--------------------|
| Valid                                              | No    | 76        | 76.0    | 76.0          | 76.0               |
|                                                    | Yes   | 24        | 24.0    | 24.0          | 100.0              |
|                                                    | Total | 100       | 100.0   | 100.0         |                    |

The survey results in Table 8 provide a clear insight into the affordability of healthcare services, specifically medications and routine checkups, among residents of Salaama Parish.

76% of respondents reported that they are unable to afford medications and routine checkups. This indicates that a significant majority of the population faces financial difficulties in accessing essential medical treatments and preventive healthcare. This high percentage suggests that

cost remains a major barrier, potentially leading to poor health outcomes due to delayed or avoided medical care. Only 24% of respondents indicated that they can afford medications and routine checkups. This minority group is likely in a better financial position, and most of them were health care providers and community leaders/local council heads; this is possibly due to the stable income these groups get or because they are able to get health insurance or access to subsidized healthcare services.

### Do You Have Health Insurance Coverage?

**Table 9: Table showing respondents who may or may not have health insurance coverage.**

| Do you have health insurance coverage? |       | Frequency | Percent | Valid Percent | Cumulative Percent |
|----------------------------------------|-------|-----------|---------|---------------|--------------------|
| Valid                                  | No    | 90        | 90.0    | 90.0          | 90.0               |
|                                        | Yes   | 10        | 10.0    | 10.0          | 100.0              |
|                                        | Total | 100       | 100.0   | 100.0         |                    |

The survey results in Table 9 highlight a significant gap in health insurance coverage among residents of Salaama Parish, revealing that the vast majority of respondents lack financial protection for medical expenses. 90% of respondents reported that they do not have health insurance coverage. This indicates that most individuals in Salaama Parish must rely on out-of-pocket payments to access healthcare, which can be a major barrier, especially

for those with limited financial resources. Only 10% of respondents indicated that they have health insurance coverage. This small percentage suggests that very few individuals benefit from financial security when seeking healthcare, likely due to factors such as affordability, lack of awareness, or limited availability of insurance programs.

### If Yes, What Type of Insurance Do You Have?

**Table 10: Table Showing the Type of Insurance That the Respondents Have.**

| Type of Insurance |                             | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------------------|-----------------------------|-----------|---------|---------------|--------------------|
| Valid             | Government health insurance | 1         | 1.0     | 10.0          | 10.0               |
|                   | Private insurance           | 9         | 9.0     | 90.0          | 100.0              |
|                   | Total                       | 10        | 10.0    | 100.0         |                    |
| Missing           | System                      | 90        | 90.0    |               |                    |
| Total             |                             | 100       | 100.0   |               |                    |

The data in Table 10 provides further insights into the types of health insurance coverage available to the small percentage of insured individuals in Salaama Parish.

Given that only 10% of respondents reported having health insurance, this follow-up question sheds light on the distribution of insurance types within this group.

Among these 10%, most of them were community leaders/ local council officials and healthcare providers. Private health insurance is the most common type, covering 9 out of 10 insured respondents (90%). This suggests that those who can afford insurance tend to rely on private providers, which may be due to the lack of accessible public or community-based insurance options. Private insurance is often associated with higher costs, which may further limit access for lower-income individuals.

Only 1% of the total respondents (10% of the insured) reported having government health insurance. This

indicates that public health insurance programs are either scarce, not widely accessible, or underutilised in the community.

Community-based health insurance (CBHI) received no responses, meaning that none of the insured individuals rely on this model. This could indicate a lack of awareness, limited availability, or low trust in community-based schemes. Given that CBHI is often designed to improve healthcare access for low-income populations, its absence suggests missed opportunities for more inclusive coverage.

### If No, What Is the Main Reason for Not Having Insurance?

**Table 11: Table Showing Respondents' Main Reason for Not Having Insurance.**

| Main reason for not having insurance |              | Frequency | Percent | Valid Percent | Cumulative Percent |
|--------------------------------------|--------------|-----------|---------|---------------|--------------------|
| Valid                                | Cost         | 49        | 49.0    | 54.4          | 54.4               |
|                                      | Availability | 14        | 14.0    | 15.6          | 70.0               |
|                                      | Awareness    | 27        | 27.0    | 30.0          | 100.0              |
|                                      | Total        | 90        | 90.0    | 100.0         |                    |
| Missing                              | System       | 10        | 10.0    |               |                    |
| Total                                |              | 100       | 100.0   |               |                    |

The data in Table 11 provides crucial insights into the barriers preventing residents of Salaama Parish from obtaining health insurance. Among the 90% of respondents who reported not having insurance, their reasons highlight key financial, structural, and informational challenges.

Cost is the most cited reason, reported by 49% of respondents (54.4% of the uninsured population). This suggests that affordability is the primary barrier, indicating that many individuals find insurance premiums too expensive relative to their income. High costs likely discourage enrollment, especially among low-income households.

Lack of awareness was the second most common reason, reported by 27% of respondents (30% of the uninsured). This suggests that a significant portion of the population may not have sufficient information about available insurance options, their benefits, or how to enroll. Limited public education and outreach efforts could be contributing to this issue.

Availability was reported as a barrier by 14% of respondents (15.6% of the uninsured). This suggests that for some individuals, health insurance options may not be accessible, whether due to geographic limitations, lack of providers, or restrictive eligibility criteria.

### How would you describe your access to clean water and sanitation facilities?

**Table 12: Table Showing the Respondents' Access to Clean Water and Sanitation Facilities.**

| Access to clean water and Sanitation Facilities |           | Frequency | Percent | Valid Percent | Cumulative Percent |
|-------------------------------------------------|-----------|-----------|---------|---------------|--------------------|
| Valid                                           | Very Good | 16        | 16.0    | 16.0          | 16.0               |
|                                                 | Good      | 32        | 32.0    | 32.0          | 48.0               |
|                                                 | Average   | 21        | 21.0    | 21.0          | 69.0               |
|                                                 | Poor      | 16        | 16.0    | 16.0          | 85.0               |
|                                                 | Very Poor | 15        | 15.0    | 15.0          | 100.0              |
| Total                                           |           | 100       | 100.0   | 100.0         |                    |

The survey findings in Table 12 on access to clean water and sanitation facilities in Salaama Parish reveal a mixed distribution of responses, highlighting significant disparities in access to essential services. 48% of respondents rated their access as either "Very Good" (16%) or "Good" (32%), indicating that nearly half of the population enjoys satisfactory access to clean water and sanitation facilities. 21% rated their access as "Average", suggesting a moderate level of access where basic needs may be met but with some limitations. 31% reported

having poor access ("Poor" – 16% and "Very Poor" – 15%), signalling a significant challenge in water and sanitation infrastructure for nearly one-third of the population.

These findings suggest that while a substantial proportion of respondents have satisfactory access to clean water and sanitation facilities, a notable percentage still experiences challenges. This disparity may contribute to health risks, particularly for those in the lower access categories.

### Have You Ever Delayed or Avoided Seeking Healthcare Due to Financial Constraints?

**Table 13: Table Showing Findings on Respondents Who May or May Not Have Delayed or Avoided Seeking Healthcare Due to Financial Constraints.**

| Delayed or Avoided Seeking |              | Frequency  | Percent      | Valid Percent | Cumulative Percent |
|----------------------------|--------------|------------|--------------|---------------|--------------------|
| Valid                      | No           | 26         | 26.0         | 26.0          | 26.0               |
|                            | Yes          | 74         | 74.0         | 74.0          | 100.0              |
|                            | <b>Total</b> | <b>100</b> | <b>100.0</b> | <b>100.0</b>  |                    |

The data in Table 13 shows that financial constraints significantly impact access to healthcare in Salaama Parish. According to the survey, 74% of respondents reported having delayed or avoided seeking medical care due to financial difficulties, while only 26% stated that they had not faced such challenges. This indicates that a majority of people struggle to afford healthcare, which may lead to worsened health outcomes due to delayed or avoided treatment.

**Table 14: Table Showing How Respondents' Employment Status Affects Their Ability to Access Health Care.**

| Employment status effect on ability to access healthcare |                                        | Frequency  | Percent      | Valid Percent | Cumulative Percent |
|----------------------------------------------------------|----------------------------------------|------------|--------------|---------------|--------------------|
| Valid                                                    | Provides stability and access          | 18         | 18.0         | 18.0          | 18.0               |
|                                                          | Insufficient income despite employment | 46         | 46.0         | 46.0          | 64.0               |
|                                                          | Unemployment creates barriers          | 35         | 35.0         | 35.0          | 99.0               |
|                                                          | Other                                  | 1          | 1.0          | 1.0           | 100.0              |
|                                                          | <b>Total</b>                           | <b>100</b> | <b>100.0</b> | <b>100.0</b>  |                    |

The survey results in Table 14 highlight significant socioeconomic disparities in healthcare access within Salaama Parish based on employment status. The majority of respondents (46%) reported that, despite being employed, their income was insufficient to guarantee stable access to healthcare. This suggests that employment alone does not necessarily ensure financial security for medical needs, likely due to low wages or lack of employer-provided health benefits. 35% of respondents indicated that unemployment creates substantial barriers to accessing healthcare. This aligns with expectations, as unemployed individuals often lack the financial means to afford medical services, insurance, or transportation to healthcare facilities.

Only 18% of participants stated that their employment provides stability and access to healthcare. This relatively low percentage underscores that stable employment with adequate benefits is not the norm for most individuals in the parish. A small percentage (1%) selected "Other," suggesting unique or less common experiences that do not fit the primary categories, and this respondent said "Not Really," which meant that the respondent's employment status had nothing to do with their ability to seek health care. These findings indicate that financial constraints, whether due to low wages or unemployment, are major obstacles to healthcare access in Salaama Parish.

## Relationship between employment status and ability to access healthcare.

**Table 15: Employment status \* How does your employment status affect your ability to access healthcare? Crosstabulation**

| Count             |            | How does your employment status affect your ability to access healthcare? |                                        |                               |       | Total |
|-------------------|------------|---------------------------------------------------------------------------|----------------------------------------|-------------------------------|-------|-------|
|                   |            | Provides stability and access                                             | Insufficient income despite employment | Unemployment creates barriers | Other |       |
| Employment status | Employed   | 18                                                                        | 42                                     | 0                             | 1     | 61    |
|                   | Housewife  | 0                                                                         | 1                                      | 14                            | 0     | 15    |
|                   | Unemployed | 0                                                                         | 3                                      | 21                            | 0     | 24    |
| Total             |            | 18                                                                        | 46                                     | 35                            | 1     | 100   |

### 1. Employment and Healthcare Access

Among the employed respondents (61 in total), 18 (29.5%) reported that their employment provides stability and access to healthcare. However, a significant proportion (42 respondents, 68.9%) indicated that their income is insufficient despite employment, limiting their ability to access healthcare. Only one employed respondent (1.6%) selected "Other" as an explanation.

**Implication:** While employment can enhance healthcare access, a large number of employed individuals still experience financial barriers to adequate healthcare, suggesting that employment does not necessarily equate to economic stability.

### Housewives and Healthcare Access

Out of 15 housewives surveyed, only one (6.7%) reported experiencing insufficient income despite their household situation. A significant proportion (14 respondents, 93.3%) stated that unemployment creates barriers to healthcare.

**Implication:** This finding suggests that dependency on a spouse or family income without personal earnings

significantly limits healthcare access, reinforcing the socioeconomic vulnerability of housewives in this community.

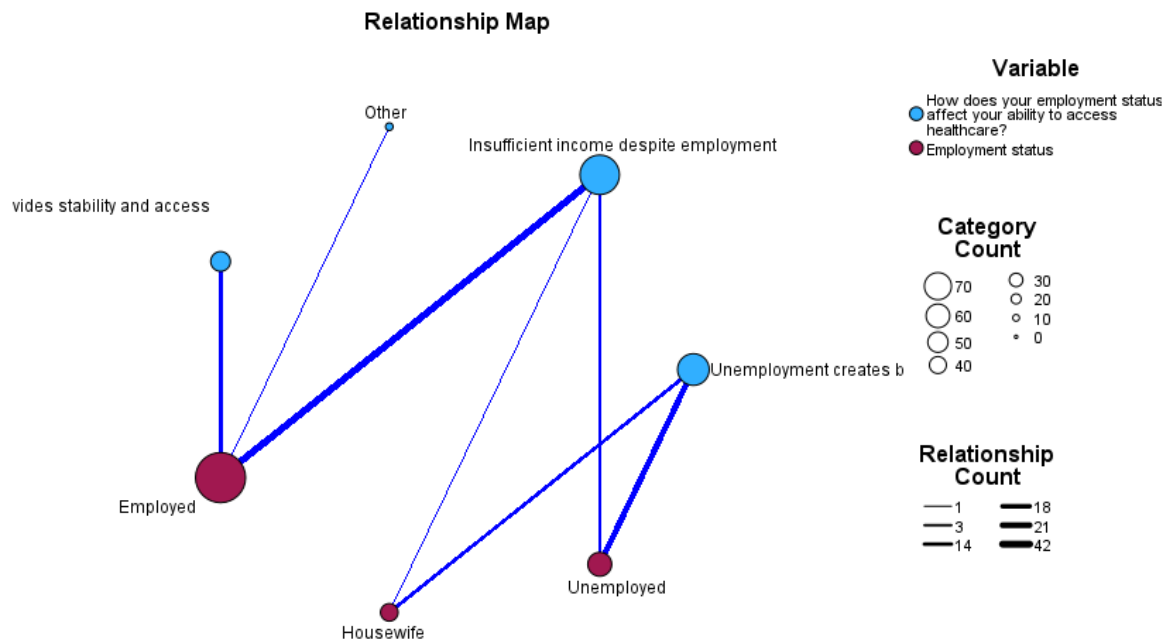
### Unemployed Respondents and Healthcare Access

Among the unemployed (24 respondents), 21 (87.5%) reported that unemployment creates barriers to accessing healthcare. Only three (12.5%) stated that they experience insufficient income despite employment, which could indicate respondents with informal or inconsistent work.

**Implication:** Unemployment is a primary barrier to healthcare, as expected. The data highlights the strong link between economic instability and limited healthcare access among those without jobs.

### Overall Trends and Disparities

A total of 46 respondents (46%) indicated that they struggle with healthcare access due to insufficient income despite employment. Unemployment was identified as a barrier by 35 respondents (35%), making it the second most significant challenge. Only 18 respondents (18%) reported stable employment providing healthcare access.



**Figure 1: Relationship Map on Employment status and How employment status affects respondents' ability to access healthcare.**

#### Employment Status and Stability in Healthcare Access

The employed group has the highest proportion of individuals (18 respondents) who report stable access to healthcare. However, the majority (42 respondents) still experience insufficient income despite employment, indicating that employment alone does not guarantee financial security or healthcare access.

This creates a weaker connection between employment and guaranteed healthcare access than might be expected.

#### Housewives and Unemployment as Barriers to Healthcare

The relationship map shows that housewives and the unemployed are overwhelmingly connected to barriers in accessing healthcare due to lack of personal income. Housewives (14 respondents) and unemployed individuals (21 respondents) are both predominantly categorized under "Unemployment creates barriers." This indicates that financial dependency or lack of stable income directly correlates with limited healthcare access.

#### Insufficient Income Despite Employment

The largest category in the dataset (46 respondents, 46%) links employment with insufficient income, suggesting that many workers still struggle to afford healthcare. This

weakens the assumption that employment is a direct solution to healthcare access. In the relationship map, this category would act as a bridge between employment and healthcare struggles, showing that economic insecurity affects both the employed and unemployed.

#### Minimal Outliers ("Other" Category)

Only one respondent selected "Other." This respondent said "Not Really," which meant that the respondent's employment status had nothing to do with their ability to seek health care, meaning that almost all individuals fall into one of the three main categories, reinforcing that financial and employment-related factors dominate healthcare access challenges.

#### Overall Relationship

The relationship map highlights a strong link between unemployment and healthcare barriers, demonstrating a direct impact. It also illustrates a weaker but still significant connection between employment and healthcare stability, since many employed individuals still face financial hardship. The largest connector is "insufficient income despite employment," showing that financial struggles affect even those with jobs.

## Do you believe your living conditions affect your health?

**Table 16: Table showing whether the respondents' living conditions affect their health or not.**

| Do you believe your living conditions affect your health? |              | Frequency  | Percent      | Valid Percent | Cumulative Percent |
|-----------------------------------------------------------|--------------|------------|--------------|---------------|--------------------|
| Valid                                                     | No           | 22         | 22.0         | 22.0          | 22.0               |
|                                                           | Yes          | 78         | 78.0         | 78.0          | 100.0              |
|                                                           | <b>Total</b> | <b>100</b> | <b>100.0</b> | <b>100.0</b>  |                    |

The data in Table 16 from the survey in Salama Parish suggests that a significant majority of respondents (78%) believe that their living conditions affect their health, while a smaller proportion (22%) do not share this belief. This finding highlights a widespread perception that environmental and socioeconomic factors play a crucial role in health outcomes.

Given that this study examines socioeconomic disparities in healthcare access and health outcomes, the high percentage of respondents acknowledging the impact of living conditions suggests that factors such as housing quality, sanitation, access to clean water, and economic stability are key determinants of health in the community.

### Discussion

The study found that 52% of respondents frequently struggled with financial constraints when seeking healthcare, and 76% were unable to afford routine checkups and medications. These findings align with Tumwesigye et al. (2016), who found that economic disparities significantly impact healthcare access in urban Uganda. Out-of-pocket healthcare costs remain a major challenge, particularly for low-income households.

Only 10% of respondents had health insurance, with 90% relying on out-of-pocket payments. This aligns with Nabukalu et al. (2021), who found that less than 2% of Ugandans are insured. Among those with insurance, 90% had private insurance, while only 10% were covered under government schemes. This highlights the need for increased public awareness and access to affordable health insurance programs.

Employment status significantly influences the ability to access healthcare services. The study found that while 61% of respondents were employed, a substantial proportion of them still faced financial challenges when seeking medical care. This indicates that employment alone does not guarantee financial security in healthcare access, especially if wages are low or if individuals are engaged in informal employment with no health benefits. Among the unemployed respondents (24%), the majority reported relying on family support or community assistance for medical expenses. To address this issue, policymakers need to consider employment-based health benefits and subsidised healthcare programs for low-income workers.

The study found that 31% of respondents rated their access to clean water and sanitation as poor or very poor. This supports WHO (2018), which highlights the link

between inadequate housing conditions and poor health outcomes. Poor sanitation and overcrowding increase the risk of communicable diseases, emphasising the need for improved living conditions.

### Conclusion

Economic factors significantly hinder healthcare access in Salama Parish, particularly through financial constraints, inadequate income, unemployment, and limited insurance coverage. Strengthening affordable healthcare programs and financial protection for vulnerable groups is essential to improve healthcare access and health outcomes.

### Limitations

The study's sample size was not representative of the entire population, potentially limiting generalizability. The study's cross-sectional design precluded causal inference, making it difficult to establish cause-and-effect relationships.

The reliance on self-reported data introduced social desirability bias, where participants provided responses that are deemed socially acceptable.

### Recommendations

Economic barriers to healthcare access can be significantly reduced by implementing affordable, government-subsidised healthcare programs targeting vulnerable groups like children, pregnant women, and the elderly.

Many residents delay treatment due to the high cost of care, leading to worsening conditions and higher long-term expenses. Expanding health insurance coverage is also critical.

Affordable community-based health insurance schemes and employer-sponsored plans should be promoted, alongside public education efforts to raise awareness about insurance benefits and ease of enrolment.

Employers should be encouraged to provide comprehensive health benefits, including insurance, paid sick leave, and wellness programs. Policy reforms must also extend healthcare coverage to informal sector workers, who represent a substantial portion of the population.

Investment in local pharmaceutical production and distribution systems will help reduce medicine shortages and costs. Strengthening supply chains and supporting

domestic manufacturing will make essential drugs more accessible and affordable in public facilities.

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### List of abbreviations

VHTs: Village Health Teams.  
IDs: In-Depth Interviews.  
SPSS: Statistical Package for the Social Sciences.  
WHO: World Health Organization  
CBHI: Community-based Health Insurance.

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### Conflict of interest

The author did not declare any conflict of interest.

### Data availability

Data are available upon request.

### Author contribution

Mark Kaukira: conceptualisation, data curation, formal analysis, methodology, investigation, funding acquisition, resources, and writing the original draft  
Rogers Talemwa: Supervision, validation, visualisation, project administration, software, reviewing and editing the draft.

All authors approved the final version of the manuscript and agreed to be accountable for the work.

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